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ISSUE PAPER — PERSON-CENTERED MEDICAL HOME PAYMENT

State of Connecticut Hospital Payment Modernization

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Overview

Connecticut's Department of Social Services' (DSS') Person-Centered Medical Home (PCMH) Program provides person-centered, comprehensive, and coordinated care. Care is organized around a person and led by a primary care provider who facilitates and coordinates a person's healthcare needs with other healthcare professionals. The PCMH program improves access to care, improves efficiency of care, and improves coordination of care, resulting in improved quality of care. There are three ways the PCMHs receive payment for this improved care:

1. Performance incentive payment.
2. Performance improvement payment.
3. Percentage increase for selected primary care codes.

The first two of these payments are retrospectively calculated on a per member per month (PMPM) basis, while the third is paid as a claim increment at the time of processing.

The current PCMH payment increments are summarized in Attachment A.

As shown, there is a different approach for hospital-based PCMHs, which was required, because a physician visit at a hospital based clinic currently follows a different administrative billing approach (outpatient fee schedule using revenue center codes [RCCs]) than a comparable visit at a non-hospital based clinic (professional fee schedule using Healthcare Common Procedure Coding System [HCPCS] codes).

Discussion

One goal of Connecticut's move toward modernized hospital payment is to have more uniformity in payment policy and create similar or identical rates or approaches for similar services. One significant change related to modernization involves a transition of all professional payments to a direct billing approach using the professional fee schedule — effectively unbundling some existing hospital payment approaches.

Given the move to direct physician billing and the unbundling of facility and professional payment, DSS must determine what changes to make to the PCMH payment approach.

The PCMH program was previously unable to use the same incremental payment measures for hospital-based PCMHs because the basis of payment was different (RCC versus HCPCS) and the claims data didn't contain the more specific procedure code information.

Under hospital payment modernization, professional services will be billed directly, eliminating the need for a separate approach for incremental PCMH payments at the RCC level for outpatient hospitals.

Considerations

Any impact of the PCMH program on the transition to the ambulatory payment classification (APC) methodology should be considered.

Data Modeling

Outpatient claims data with dates of services from 5/1/2014 through 12/31/2014 will be used to develop the APC conversion factor. Two outpatient hospitals participated in the PCMH program during this time period, and the PCMH incremental payments will be excluded from the development of the APC conversion factor as summarized in the table below.

Hospital Name	Hospital Number	Clinic Rate (RCC 510, 515 & 519)	PCMH Percentage	Anticipated PCMH Payment
Danbury Hospital	004025227	$57.23	16% (level 3)	$9.16
St Francis Hospital Medical Ctr-Gengras Clinic	004024923	$57.23	9% (glide path)	$5.15

Specifically, RCCs 510, 515, and 519 will be capped at $57.23 for these two PCMH hospitals. Payments greater than $57.23 will be identified as PCMH payments and will not be included in the APC conversion factor.

Fiscal Impact

Going forward, the PCMH program will be entirely physician-based and therefore not relevant to the outpatient hospital rate methodology. Any fiscal impact of the change to PCMH payment methods will be reviewed with consideration of the APC conversion factor development.

Conclusion

With the move to direct billing for all professional services, the goal of unbundling and uniformity of payment, the outpatient portion of the PCMH payment schedule should be retired. The hospital-based PCMH practices should apply for PCMH status as a professional practice and receive PCMH payments based on their direct billing and the physician-based PCMH incremental payment schedule.

Attachment A

PCMH Reimbursement Summary

Clinic Type	Payment Type	Basis for payment	Payment Amount		
			Glide Path	NCQA Level 2	NCQA Level 3
Independent Adult	% Increase [1]	Primary Care Codes – PCMH specific	14%	20%	24%
	PMPM [2]	Performance *Incentive* Payment		$0.60	$0.60
	PMPM [2]	Performance *Improvement* Payment		$0.68	$0.68
Independent Pediatric	% Increase [1]	Primary Care Codes – PCMH specific	14%	20%	24%
	PMPM [2]	Performance *Incentive* Payment		$0.60	$0.60
	PMPM [2]	Performance *Improvement* Payment		$0.68	$0.68
Hospital Outpatient	% Increase [1]	Hospital Revenue Center Codes - PCMH specific	9%	14%	16%
	PMPM [2]	Performance *Incentive* Payment		$0.97	$0.97
	PMPM [2]	Performance *Improvement* Payment		$0.81	$0.81

[1] Percentage Increase applies to the PCMH specific Primary Care Codes and Hospital Revenue Center Codes based on CT Medicaid fee-for-service base rates

[2] Per member, per month (PMPM) performance and improvement payments apply only to those members attributed to a PCMH practice and who are continuously enrolled over the calendar year. Attribution is determined by either member self-selection or by primary care specific services rendered. Thus, the actual number of HUSKY Health members attributed to a PCMH practice will be a subset of the practice's total HUSKY Health panel size and the incentive payments are adjusted accordingly.